Patient History

Name:_____ Patient #: _____ Age: _____ Date:_____

Address: _____
Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: ( ) _____ Work Telephone Number: ( ) _____

Social Insurance Number: _____ Birthdate: _____ Male: ___ Female: ____

Employer's Name and Address:_____

Single: ___ Married: ___ Divorced:____ Widowed:____ e-mail address:_____

Number of children: _____ Would you like to be a member of our website? Yes: _____ No:_____

Reason for consulting our office: _____

Who referred you to our office?_____Spouse's name: _____

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

Comments:_____

_____

Adult Years (Age 18 to present)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do/did you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your stress level:
(1 = none, 10 = extreme)

Occupational:_____ Personal: _____

On a scale of POOR, GOOD, or EXCELLENT, describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here _____ and skip to "**Family Health Profile**". Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life.

_____

_____

If you are experiencing pain, is it:

☐ Sharp ☐ Dull ☐ Comes & Goes ☐ Travels ☐ Constant

Since the problem started, it is: ☐ About the Same ☐ Getting Better ☐ Getting Worse

What Makes It Worse: _____

It Interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem:

☐ Chiropractor _____
☐ Medical Doctor _____
☐ Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Pins & Needles in Arms	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Loss of Taste	☐ Upset Stomach
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping Problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Sensitive Eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking: _____

_____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____
Spouse: _____
Mother: _____
Father: _____
Brother(s): _____
Sister(s): _____
Others: _____

Have you ever:

Bought bottled water? ☐ YES ☐ NO
Belonged to a health club? ☐ YES ☐ NO
Consumed vitamins or supplements? ☐ YES ☐ NO

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____
Signature Date